Iowa Department of Human Services

Iowa Medicaid - Provider Enrollment Application

Basic Information

To avoid delays in the enrollment process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the application approval process.
- Attach all required supporting documentation.

Mail the completed Provider Application and all applicable attachments to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, Iowa 50315

Required Forms: Forms are found on the DHS webpage at: http://dhs.iowa.gov/ime/providers/forms.

New enrollees and those with a new Tax Identification Number (ID):

If you are enrolling in the Medicaid program for the first time or already enrolled, but have a new Tax ID, the following forms are required:

- Form 470-0254, Iowa Medicaid-Provider Enrollment Application
- Form 470-2965, Provider Agreement
- Form 470-4202, Electronic Fund Transfer (EFT) Authorization
- IRS Form W-9
- Form 470-5112, Designated Contact Person

Only if applicable:

- Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia
- Form 470-3748, Verification of Ambulance Compliance LEA Agreement (Local Education Agency)
- I/T Contract (Early Access Service Coordinator)
- Form 470-5100, Health Home Agreement
- Form 470-3747, Point of Sale (POS) Agreement - Pharmacies only

Adding an individual or sub-part to your organization:

- If the Tax ID is already enrolled and active, the following form is required:
  Form 470-0254, Iowa Medicaid-Provider Enrollment Application (Pages 9 and 10)

Instructions for Completing the Iowa Department of Human Services
Iowa Medicaid Provider Enrollment Application

Reason for Application: Check one box.

Section A: General Information

This section is completed only for Tax Identification Numbers (IDs) enrolling with Iowa Medicaid for the first time.

Organizational Data

1. Enter the full name of the practice as it appears on your income tax return.
2. Enter the nine-digit Federal Employer Identification Number (FEIN) of the business or the Social Security Number (SSN) of the individual for which this application is being filed. **Note:** If you are adding an individual to an existing group, enter the FEIN of the group. Check the box to indicate which number you are listing.
3. Enter your Primary Organizational National Provider Identifier (NPI). This is the NPI you will use to bill Iowa Medicaid. If you are not a "health care provider" as defined at 45 C.F.R. §160.103, please complete the Atypical Declaration Form, found on the DHS webpage at: http://dhs.iowa.gov/ime/providers/forms .
4. Primary physical location:
   a. Enter the street number of your primary office location.
   b. Enter your suite or apartment number.
   c. Enter the city name.
   d. Enter the state name.
   e. Enter the zip code.
5. Enter the county name.
6. Enter the phone number.
7. Enter the fax number.
8. Check the box that best matches the type of business being enrolled:
   a. Check the appropriate box.
   b. The 340B Drug Pricing Program resulted from the enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. A 340B provider is able to acquire drugs through that program at significant discounted rates. Because of the discounted acquisition cost on these drugs, such are not eligible for the Medicaid drug rebate. State Medicaid programs are obligated to assure that rebates are not claimed on these drugs. Please refer to Informational Letter 699 for more information. If "Yes" enter the effective date.
9. Mailing address for Medicaid-related correspondence:
   a. Enter the mailing address if it is different from the address provided in box 4.
   b. Enter the city name.
   c. Enter the state name.
   d. Enter the zip code.
10. Enter the email address for Medicaid-related correspondence.

Payment Information

11. Payment method:
    a. Check one box: An Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolling using a Federal Employer Identification Number (FEIN) of the business. A debit card is only an option if an individual is doing business under a Social Security Number in box 2.
    b. Enter the pay-to address: This address is used for mailing of the debit card and 1099s.

Pharmacies Only

12. Pharmacies only enter:
    a. The National Council for Prescription Drug (NCPDP) number.
    b. Acknowledgement: If you are a pharmacy that is located outside of the state of Iowa, check one box.

Independent Labs Only

13. Independent labs enter:
    a. The 10-digit Clinical Laboratory Improvement Amendments (CLIA) certification code. Please attach a copy of your current CLIA certification.
    b. The effective date.
    c. The termination date.

Note: If you are enrolling more than one location, please attach CLIA certification for each location.

14. Leave blank (For Future Use)

15. Leave blank (For Future Use)

Page 8 is a listing of Iowa Medicaid provider types. Use this list to identify your provider type code, if an application fee is applicable and to determine whether additional certifications are required for enrollment. Enter the type code in box 16 of the application. Attach the required additional certification to your application.

Note: Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

Section B: Identifying Information

Page 9-10 is used to enroll individual/group professional or institutional categories (from the listing) that are part of the business and subject to the Iowa Medicaid Provider Agreement. Additional copies of page 4 must be completed for each individual within the organization who is being enrolled.

16. Enter the type code from the list on page 8.

17. Enter the licensee or “doing-business-as” name. For individuals that are part of an organization, list the individual’s name.

18. a. Tax ID: Enter the Tax ID of the entity to which payment will be made.
    b. Social Security Number (SSN): Enter the nine-digit SSN for the individual entered in box 17. No entry is required if provider is an organization.
    c. Date of birth: Enter the DOB for the individual entered in box 17. No entry is required if it is an organization.

19. Enter the requested effective date of the enrollment.

20. Enter the physical address of the service location. Note that each service location must be listed for which medical records are stored, or for where MediPASS patients are seen. Make additional copies of page 9-10 as needed to indicate more than three service locations.
    a. Enter the primary service address.
    a1. Enter the phone number, fax number, and email address of the service location for which the application is being made.
    b. Enter an additional service location, if any.
    b1. Enter the phone number, fax number, and email address of the additional service location.
    c. Enter a third additional service address, if any.
    c1. Enter the phone number, fax number, and email address of the additional service location.

21. Enter the pay-to address. The address is only needed if the NPI being enrolled will be the pay-to provider

Note: Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business and the NPI in box 23a will be the pay-to NPI. This address is used for mailing the debit card and 1099s.

22. Enter the mailing address.

23. Enter the NPI.
    a. Enter the NPI of the individual or organization named in box 17.
    b. Enter the taxonomy code of the billing provider. **Note:** If the individual listed in box 17 is a member of a group, this box is not required and may be left blank.

24. Primary professional license or certification number:
    a. Enter the primary professional license or certification number and attach a copy of your license or certification documents, as listed on page eight for the type code listed in box 16.
    b. Enter the 10-digit CLIA Certification code. If you are providing lab services which require CLIA certification, submit a copy of your current CLIA certification.
    c. Enter the state in which this license or certification was issued.
    d. Enter the initial effective date of the license listed in box 24a.
    e. Enter the license expiration date for the license listed box 24a.
    f. Enter the effective date for the CLIA certificate listed in box 24b.
    g. Enter the expiration date for the CLIA certificate listed in box 24b.

25. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A. If the provider is a physician, the number must be entered.

26. For physicians only: Enter the primary specialty, if applicable.

27. For physicians only: Enter the secondary specialty, if applicable.

28. Check the ***Yes*** box if there has ever been disciplinary action against this provider's license by a licensing board in any state and attach an explanation. Check ***No*** if there has not been any disciplinary action.

29. a. Check the ***Yes*** box if Medicare or any state health program has ever sanctioned the provider and attach an explanation. Check ***No*** is there have not been sanctions.

b. Check the ***Yes*** box if convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program and attach an explanation. Check ***No*** if there have not been any convictions.

30. Group linkage information: If the individual referenced in box 17 will be linked to a group, enter the group information here. **Note:** If the NPI, taxonomy, and zip code provided do not match a group already enrolled in Iowa Medicaid, the application will be returned for corrections. Page 9-10 must be completed to enroll a group.
    a. Enter the organization NPI with which the individual profession is associated. This is the NPI under which payments will be made.
    b. Enter the organizational taxonomy code.
    c. Enter the organizational zip code.
31. Check ***Yes*** or ***No*** if you are enrolled in another state's Medicaid or CHIP program. If yes, please list the states and the program.
32. Check ***Yes*** or ***No*** if you are enrolled with Medicare.
33. Certification:
    a. Enter the printed name of the legal entity.
    b. Enter the printed name and title of the authorized signer.
    c. The authorized signatory signs here.
    d. Enter the date of the signature.

Note: If a new Tax ID is being enrolled with Iowa Medicaid for the first time, the Ownership and Control Disclosure must be completed online before your Tax ID will be activated. To start this task it is necessary to designate a contact person for your organization using form 470-5112. This will provide access to the online tool used to disclose ownership and control.

Section A: Organizational Data

Reason for Application: Check one box

☐ **NEW** enrollee in Medicaid (the Tax Identification or Social Security Number has not been enrolled in Medicaid)	☐ **CHANGING** to a new Tax Identification Number. (already enrolled, but have a new Tax Identification Number)

Practice Information

1. Legal Name (as it appears on your income tax return)			
2. Taxpayer Identification Number (TIN): Enter the nine-digit Federal Employer Identification Number (FEIN) of the business **or** the Social Security Number (SSN) of the individual for which this application is being filed. This is the number under which all income will be reported to the Internal Revenue Service for Federal 1099 purposes. ***Indicate type:*** ☐ FEIN or ☐ SSN (check one) ***List the number here:***			
3. For Healthcare Providers: Primary Organizational NPI			
4a. Primary Physical Location*			**4b.** Suite Number
4c. City	**4d.** State	**4e.** Zip Code	**5.** County
6. Phone Number		**7.** Fax Number	
8a. Check Appropriate Box ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Limited Liability Company (LLC) ☐ Individual ☐ Corporation ☐ Nonprofit Corporation ☐ Cooperative ☐ Other _____			
8b. Is your organization a participating "340B" provider? ☐ Yes Effective date: _____ ☐ No			
9a. Mailing Address (Medicaid-related correspondence, if different from above)			
9b. City		**9c.** State	**9d.** Zip Code
10. Email Address for Medicaid-Related Correspondence			

Payment Information

11a. Payment Method: ☐ *Electronic Funds Transfer ☐ **Debit Card

NOTE: *EFT REQUIRES COMPLETION OF AUTHORIZATION FORM (470-4202).
**** Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number (in box 2).**

11b. Pay-to Address (only used for debit card mailing and 1099s)

Address		Suite Number
City	State	Zip Code

For Pharmacies Only

12a. Enter the National Council for Prescription Drug Programs (NCPDP) Number

12b. Acknowledgement for pharmacies located outside the state of Iowa: According to the Iowa Administrative Code 657-19.2(155A), a pharmacy located outside of Iowa shall apply for and obtain, pursuant to provisions of 657-8.35(155A), a nonresident pharmacy license from the board prior to providing prescription drugs, devices, or pharmacy services to an ultimate user in this state. Please complete the acknowledgement below.

Check one:

- ☐ **The rule listed above does not apply to the pharmacy that is applying to be a provider with the Iowa Medicaid Program.**
- ☐ **The rule listed above does apply to this pharmacy; please attach a copy of the Iowa nonresident pharmacy license.**

For Independent Lab Only

13a. 10-digit Clinical Laboratory Improvement Amendments (CLIA) Number

13b. Effective Date	**13c.** Termination Date

14. Leave Blank (For Future Use)

15. Leave Blank (For Future Use)

Master Provider Listing

Use this list to identify your provider type code. Enter the type code in box 16.

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification document(s) as indicated on the list below.
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.
- **Categories in bold below are considered Moderate or High risk and subject to a pre/post enrollment site visit and other enhanced screening requirements.**

Type Code	Category	Primary Certification	Additional Certification
1	General Hospital	CMS certification	License *CLIA
2	Physician MD	License	*CLIA
3	Physician DO	License	*CLIA
4	Dentist	License	
5	Podiatrist	License	
6	Optometrist	License	
7	Optician		
8	Pharmacy	License	Medicare enrollment
9	**Home Health Agency**	CMS certification	
10	**Independent Lab**	CLIA certificate	Medicare enrollment
11	**Ambulance**	License	
12	**Medical Supplies**	Medicare enrollment	
13	Rural Health Clinic	CMS certification	
14	ESRD	CMS certification	
15	**Physical Therapist**	License	Medicare enrollment
16	Chiropractor	License	Medicare enrollment
17	Audiologist	License	
18	Skilled Nursing Facility	DIA/CMS certification	License
19	**Rehab Agency**	CMS certification	
20	Intermediate Care Facility	DIA/CMS certification	License
21	**Community Mental Health**	Bureau of Community Services	
22	Family Planning	Dept Public Hlth approval	
23	Residential Care Facility	License (DIA)	
25	ICF/ID State	DIA/CMS certification	License
26	Mental Hospital	CMS certification	License
27	Community-Based ICF/ID	DIA/CMS certification	License
29	Psychologist	License	NRHSPP cert
30	Screening Center	Dept Public Health approval	
31	Hearing Aid Dealer	License	
32	Occupational Therapists	License	Medicare enrollment
34	Orthopedic Shoe Dealer		
35	Maternal Health Center	DHS approval	
36	Ambulatory Surgical Center	CMS certification	
38	Certified Nurse Midwife	License	Board cert *CLIA
39	Birthing Center	DHS approval	
40	Area Education Agency	IA Dept of Education Agreement	
41	Psych Medical Inst. Children (PMIC)	DIA license	
42	Case Manager	DHS approval	
44	CRNA	License	Board cert
45	**Hospice**	CMS certification	*CLIA
48	Clinical Social Worker	License	Medicare enrollment
49	Federal Qualified Health Center (FQHC)	CMS certification	HRSA grant
50	Nurse Practitioner	License	Board cert *CLIA
52	Nursing Facility - Mentally Ill	DIA/CMS certification	License
54	County Relief	DHS approval	
55	Lead Investigation Agency	Dept Public Hlth approval	
56	Local Education Agency	IA Dept of Education Agreement	
57	Early Access Service Coordinator	IA Dept of Education Agreement	
58	PACE	CMS PACE agreement	
62	Behavioral Health	License	
63	Behavioral Hlth Intervention Srvs (BHIS)	Magellan enrollment welcome letter	
64	Habilitation Services	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
69	Independent Speech Pathologist	License	
71	Health Home	TransforMED self-assessment or NCQA recognition	Health home agreement
72	Public Health Agency	Board of Health Jurisdiction letter	
76	Accountable Care Organization		ACO agreement
99	Waiver	HCBS application required	

Section B: Identifying Information

Please copy this page and complete one for each individual professional and institutional category.

Reason for Application: Check one box

☐ **New** group, individual practitioner or institutional category that is part of the Tax ID and subject to the Iowa Medicaid provider agreement.	☐ **Adding New Location**. If you are adding a new location to a Tax Identification Number already enrolled in the Iowa Medicaid program.

16. Type Code	**17.** Licensee or DBA Name	**18a.** Tax ID (for billing entity)	
18b. Social Security Number	**18c.** Date of Birth	**19.** Requested Effective Date of Enrollment*	
20a. Primary Service Address	City	State	Zip
20a1. Primary Address Phone Number	Fax	Email	
20b. Additional Service Address	City	State	Zip
20b1. Additional Service Address Phone Number	Fax	Email	
20c. Additional Service Address*	City	State	Zip
20c1. Additional Service Address Phone Number	Fax	Email	
21. Pay-to Address	City	State	Zip
22. Mailing Address	City	State	Zip

23a. National Provider Identifier (NPI)		**23b.** Taxonomy Code (if applicable)	
24a. Primary Professional License or Certification Number – **Please attach a copy of your license/certification documents.**		**24b.** 10-Digit CLIA Number	**24c.** State Issued
24d. Initial Effective Date	**24e.** Current Expiration Date	**24f.** CLIA Effective Date	**24g.** CLIA Expiration Date
25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.			
26. Primary Specialty* (if applicable)		**27.** Secondary Specialty* (if applicable)	

28. Has there ever been disciplinary action against this provider's license by a licensing board in any state?

☐ **Yes** ☐ **No** **If "Yes," please attach an explanation.**

29a. Has the provider ever been sanctioned by Medicare or any state health program?

☐ **Yes** ☐ **No** **If "Yes," please attach an explanation.**

29b. Has the provider been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or the Title XX services program?

☐ **Yes** ☐ **No** **If "Yes," please attach an explanation.**

Payment Method Information: EFT is required when billing under a Federal Tax ID Number.
Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number.

Group Linkage Information*

Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:

30a. Organizational NPI	**30b.** Organizational Taxonomy	**30c.** Organization Location Zip

31. Are you currently enrolled in another state's Medicaid/CHIP program?

☐ **Yes** ☐ **No** **If "Yes," please list the state and what program you are enrolled in:**

32. Are you currently enrolled with Medicare? ☐ **Yes** ☐ **No**

The provider certifies that the information submitted on this enrollment is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

33a. Printed Name of Legal Entity	
33b. Printed Name and Title of Authorized Signatory	
33c. Signature of Authorized Signatory	**33d.** Signature Date

Please mail this completed Provider Application and all applicable attachments to:
Iowa Medicaid Enterprise, Attn: Provider Enrollment,
PO Box 36450, Des Moines, Iowa 50315